O S T O M Y S U R V E Y

Dear Ostomate / Ostomist:

We are collecting data on the ostomy and pouching experiences of folks who have ostomies. We would greatly appreciate your voluntarily contributing information on this survey form. Do not worry if you can not recall all that is asked in this form. We encourage you to write in additional notes on space provided.

Rest assured your personal identity and privacy will remain anonymous and protected. You will note we are not asking you to provide any identifying traits. Eventually, we would like to present the data as a diorama or history of ostomy experiences that will, hopefully, show how these experiences may have influenced adjustment to ostomy life and how ostomates / ostomists are meeting their current needs.

Mike D'Orazio ET, BA, M.Mgt.

Ostomy Consultant

1. Current date ____/____/_____ ID # «clientnumber»	2. Current age	3. Gender ☐ M ☐ F ☐Other	4. Current Ostomy Type(s) ☐ Colo ☐ Ileo ☐ Uro

The following items (5 – 33) pertain only to your initial or first time ostomy experiences. Do not include information about your present ostomy experiences.

5. Date of first ostomy ____/____/_____	6. Age at first ostomy	7. Reason for ostomy

8. Was ostomy surgery planned (elective) or unexpected (emergency)?

9. Did the physician and or ET Nurse do a preoperative stoma site assessment? (check all that apply) If not, skip #s 10 & 11)

Physician ☐ No ☐ Yes ET Nurse ☐ No ☐ Yes

10. Did you actively participate in the stoma siting process?

☐ No ☐ if Yes, mark all that apply> ☐ sitting ☐ standing ☐ lying down ☐ wearing trial pouch

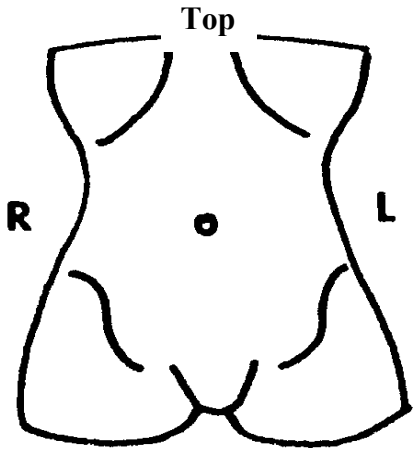
11. Where did the stoma siting process take place? (check all that apply)

☐ hospital room ☐ ET Nurse's office ☐ Doctor's office ☐ home

12. First ostomy type(s) Incontinent: ☐Colo ☐Ileo ☐Uro Continent: ☐Colo ☐Ileo ☐Uro	13. Construction of first ostomy (mark all that apply) ☐End ☐loop ☐double-barrel ☐retracted ☐flush ☐protruding ☐round ☐oval

14. Location of stoma(s) and incision(s) [clearly label all stomas and incisions directly on sketch]

[Note: the **R** and **L** refer to patient's own right and left side of abdomen]



15. Stoma size, shape and length upon initial ostomy hospital discharge (if more than one active stoma, note measurements and shapes with a dash between each

Diameter (inches) _____-_____ Shape (round or oval)_____-_____ Length (inches) ____-_____

16. Hospital

Name_____

City _____ State _____

17. Surgeon's title and specialty ☐MD ☐DO

☐General surgery ☐Colo-Rectal surgery ☐Urology

☐ Gynecology ☐ other_____

18. Length of hospital stay for first ostomy [admission date (mm/dd/yy) to discharge date (mm/dd/yy)]

From _____ to _____ = _____ weeks _____days

19. Initial reactions to ostomy, and experiences **before** final or "permanent" pouch fitting

☐Good ☐Fair ☐Poor ***[please elaborate below or on additional paper as needed]***

20. Initial reactions or experiences **after** final or "permanent" pouch fitting

☐Good ☐Fair ☐Poor ***[please elaborate below or on additional paper as needed]***

21. Were you seen by an ostomy visitor during this first ostomy hospitalization? ☐NO ☐YES

22. Was the visitor a member of an ostomy group? ☐NO ☐YES (name)_____

23. Who arranged or initiated the ostomy visitor?

☐Family ☐Friend ☐Physician ☐ ET Nurse ☐Social Worker ☐Pastor ☐Other _____

24. Pouch manufacturer or supplier and pouch model name and number

Manufacturer _____ Model _____ Number _____

25. Pouch style or design	26. Pouch material	27. Pouch structure	28. Faceplate features
☐ Closed ☐ Drainable ☐ Reusable ☐ Disposable	☐ Rubber ☐ Plastic ☐ Clear ☐ Opaque	☐ One-piece ☐ Multi-piece	☐ Convex ☐ Concave ☐ Flat ☐ Round ☐ Oval ☐ Hard ☐ Soft

29. Skin protector used?	30. Belt(s) used?	31. Adhesive used?
☐No ☐Yes Type _____ Brand _____	☐No ☐Yes Type _____ Brand _____	☐No ☐Yes Type_____ Brand _____

32. Has original stoma been revised?

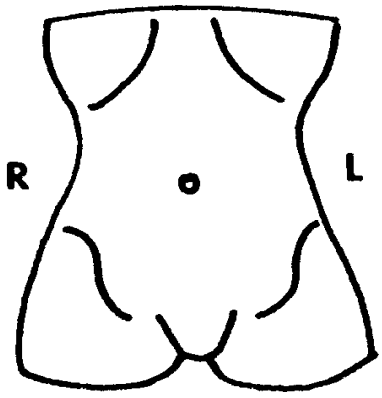
☐No ☐Yes

When ____/____/_____ Why _____

33. Has original stoma been repositioned or relocated? ☐No ☐Yes

When_____/____/_____ Why _____ Where (mark on sketch below)

Show old stoma site with an "X" and repositioned one with a circle "O"



Additional comments:

Initial reactions to ostomy and experiences **before** final or "permanent"pouch fitting

Initial reactions or experiences **after** "permanent" pouch fitting

_____

_____

The remaining items pertain only to ostomate's stoma clinic experiences and are to be filled out by the ET Nurse.

34. Current date ____/____/_____ ID # «clientnumber»	35. Current age	36. Gender ☐ M ☐ F ☐ Other	37. Current Ostomy Type(s) Incontinent: ☐ Colo ☐ Ileo ☐ Uro Continent: ☐ Colo ☐ Ileo ☐ Uro

38. Why did client attend the stoma clinic? (mark all that apply)
☐ Curiosity ☐ General Information ☐ Specific concern: Explain_____

39. ASS: (check all that apply)

Appliance #1: brand_____ model_____ number(#)_____

Appliance #2: brand_____ model_____ number(#)_____

☐one-piece ☐two-piece ☐flat ☐convex ☐concave ☐opaque ☐transparent ☐drainable
☐closed end ☐disposable ☐reusable ☐separate closure ☐integral closure ☐stoma cap ☐catheter
☐other_____

Is wafer/seal uncomfortable against body? ☐ No ☐ Yes: Explain_____

Describe client's normal pouching techniques and products used at each wafer/pouch change:_____

_____

Skin (peristomal): ☐healthy ☐dry ☐moist ☐macerated ☐inflamed ☐excoriated ☐infected
☐smooth ☐rough ☐supple ☐taught ☐creased or dimpled ☐loose(flaccid) ☐thin ☐obese ☐hairy
☐herniated ☐hyperpigmented ☐hypopigmented ☐ caput medusae ☐lesions: Explain_____

_____

Does skin need urgent medical / surgical attention? ☐ No ☐ Yes: Explain_____

_____

Stoma: ☐healthy ☐moist ☐dry ☐temporary ☐permanent ☐round ☐oval ☐long ☐bud ☐flush
☐mushroom shaped ☐os (orifice) centered ☐os slanted ☐os flush ☐os hidden ☐retracted
☐herniated ☐intussuscepted ☐end ☐loop ☐double-barreled ☐bleeding ☐pale ☐dusky
☐necrotic ☐stenotic ☐edematous ☐lacerated ☐ infected ☐polyps/granulomas ☐ mucosal islands
Does stoma need urgent medical / surgical attention? ☐ No ☐ Yes: Explain_____

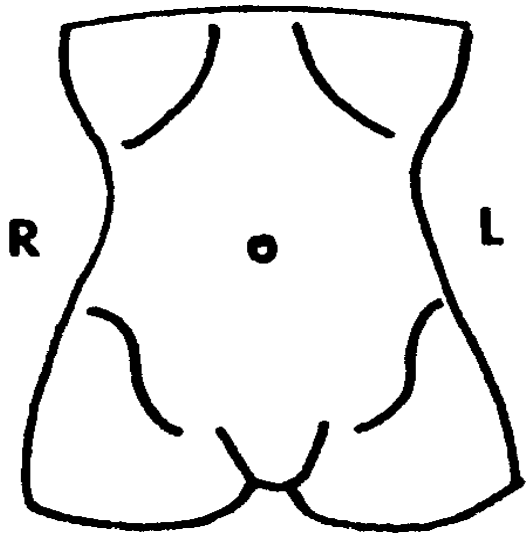
_____

Measure stoma dimensions: Diameter _____" @ _____ o (degrees) Length _____"

40. Location of stoma(s) and incision(s) [clearly label all stomas and incisions directly on sketch]

[Note: the **R** and **L** refer to patient's own right and left side of abdomen]

Top



Illustrate belt clothing or waist line with a dashed line (--------)

41. **SPD (Stomal Plane Dynamics):** (check all that apply)

Wafer/faceplate fails to maintain continuous contact with skin (gaposis). ☐ No ☐ Yes: Explain_____

_____

Is mucocutaneous junction disrupted? ☐ No ☐ Yes

Does stoma configuration / location adversely affect application and seal? ☐ No ☐ Yes: Explain _____

_____

Does client prepare / apply pouch unit inappropriately? ☐ No ☐ Yes: Explain_____

_____

Does **dynamic** creasing or shifting of peristomal skin disrupt skin seal? ☐ No ☐ Yes

Does **static** creasing or shifting of peristomal skin disrupt skin seal? ☐ No ☐ Yes

Do adjacent topographies (scars, creases, artifacts, bony prominences, etc.) interfere with wafer / seal integrity? ☐ No ☐ Yes: Explain_____

Does clothing interfere with pouch / wafer integrity? ☐ No ☐ Yes: Explain_____

_____

Does peristaltic activity adversely affect seal? ☐ No ☐ Yes

Does current skin condition / integrity adversely affect seal? ☐ No ☐ Yes: Explain_____

_____

Do recent weight changes (+ or -) adversely affect seal? ☐ No ☐ Yes: Explain_____

_____

Does medication (systemic or topical) adversely affect seal? ☐ No ☐ Yes: Explain_____

_____

Is pouch/wafer change cycle inappropriate? ☐ No ☐ Yes: Explain_____

_____

Do you think client needs wafer / faceplate convexity? ☐ No ☐ Yes: Explain_____

_____

42. **Effluent:** (questions pertain to normal or general circumstances)

Is coloring inappropriate? ☐ No ☐ Yes: Explain _____
Is it malodorous? ☐ No ☐ Yes: Explain _____
Is texture inappropriate for stoma type? ☐ No ☐ Yes: Explain _____
Is volume inappropriate? ☐ No ☐ Yes: Explain _____
Is flatus troublesome? ☐ No ☐ Yes: Explain _____
Is effluent exit impeded? ☐ No ☐ Yes: Explain _____

43. **PPP (Preferred Pouch Profile):** (check all that apply)

Is current pouch **not** meeting client's needs and desires? ☐ No ☐ Yes: Explain _____

_____

Is pouch shape **not** satisfactory? ☐ No ☐ Yes: Explain _____

Is pouch volume **not** satisfactory? ☐ No ☐ Yes: Explain _____

Is pouch material **not** acceptable? ☐ No ☐ Yes: Explain _____

How does client suspend pouch? ☐straight up and down ☐sideways ☐slightly askew away from groin

☐slightly askew toward groin ☐other_____ Explain client's rationale_____

_____

Does client fold up pouch to minimize appearance? ☐ No ☐ Yes: Explain_____

Does folding up pouch help or hinder appearance from client's perspective? ☐help ☐hinder

Does folding up pouch help or hinder from ET perspective? ☐help ☐hinder: Explain_____

_____

How often does client empty pouch during waking hours? ☐once ☐2-3 ☐4-5 ☐6-7 ☐8-9 ☐10+

How often does client empty pouch during sleeptime? ☐once ☐2-3 ☐4-5 ☐6-7 ☐8-9 ☐10+

Does client restrict some activities because of perceived pouch limits? ☐ No ☐ Yes: Explain_____

_____

Is client content with above emptying cycles? ☐ No ☐ Yes

Is client **not** using a belt? ☐ No ☐ Yes

Would client benefit from a belt? ☐ No ☐ Yes: Explain_____

_____

44. Additional observations about client and & comments about perceived utility of this survey:_____

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_____ **Thank you!**